Nationwide Healthcare

Portland Road Family Dental Centre

Inspection Report

7 Portland Road
Hucknall
Nottingham
Nottinghamshire
NG15 7SL
Tel: 01159 790909
Website: www.portlandroaddental.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 18 February 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

Portland Road Family Dental Centre is situated over two floors of premises close to the centre of Hucknall in north Nottinghamshire. The practice was registered with the Care Quality Commission (CQC) in October 2011. The practice provides regulated dental services to patients from Hucknall and the surrounding area. The practice provides mostly NHS dental treatment. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are: Monday to Friday: 8 am to 6 pm. The practice is closed at the weekend.

Access for urgent treatment outside of opening hours is by ringing the practice and following the instructions on the answerphone message. Alternatively patients should ring the 111 telephone number for access to the NHS emergency dental service.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service.

Summary of findings

Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice has six dentists; there are six trainee dental nurses one of whom also works on reception, plus two receptionists and one practice manager.

We received positive feedback from 33 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

Our key findings were:

- Patients spoke positively about the dental services they received, and said they were treated with dignity and respect.
- Treatment options were identified, explored and discussed with patients.
- Patients' confidentiality was maintained.
- There were systems in place to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- There was a detailed whistleblowing policy and procedures for both internal and external use, and staff were aware of these procedures and how to use them. All staff had access to the whistleblowing policy.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included oxygen and emergency medicines.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Dentists involved patients in discussions about the care and treatment on offer at the practice. Patient recall intervals were in line with National Institute for Health and Care Excellence (NICE) guidance.

There were areas where the provider could make improvements and should:

- Review the storage arrangements of chemicals in the cleaning cupboard to ensure they are stored securely and in accordance with the Control of Substances Hazardous to Health (COSHH) Regulations 2002.

Make arrangements to facilitate the monitoring of the temperature of the water used in the scrubbing sink in the decontamination room. This would support effective cleaning of the dental instruments.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Accidents and significant events were recorded and learning points were shared with staff.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely.

X-rays were carried out safely in line with published guidance, and X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

All patients were clinically assessed by a dental professional before any treatment began. This included completing a health questionnaire or updating one for returning patients. The practice used a recognised assessment process to identify any potential areas of concern in patients' mouths, jaws and neck, including their soft tissues (gums, cheeks and tongue). Additional assessments were completed on children to ensure preventative measures for tooth decay were effective.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Staff were able to demonstrate that referrals had been made in a timely way when necessary.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Staff understood the need for maintaining patient confidentiality and were able to demonstrate how they achieved this in both the reception area and the treatment rooms.

Summary of findings

Patients said they were well treated, and staff were polite and caring. Feedback identified that the practice treated patients with dignity and respect.

Staff at the practice were friendly and welcoming to patients and made efforts to help anxious patients relax.

Patients said they received good dental treatment and they were involved in discussions about their dental care.

Patients said they were able to express their views and opinions.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Patients said it was easy to get an appointment. Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The practice had three ground floor treatment rooms, so that patients with restricted mobility could access the practice and receive treatment.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room, and in the practice leaflet.

The practice had a hearing loop, to assist patients who used a hearing aid.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

The practice was carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided.

Patients were able to express their views and comments, and the practice listened to those views and acted upon them. Regular feedback was given to patients following surveys to gather patients' views.

Staff said the practice was a friendly place to work, and they could speak with the dentists if they had any concerns.

Portland Road Family Dental Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 18 February 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with six members of staff during the inspection.

We also reviewed the information we held about the practice and found there were no areas of concern.

During the inspection we spoke with three dentists, and two dental nurses, two receptionists, and the practice manager. We reviewed policies, procedures and other documents. We received feedback from 33 patients about the dental service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice recorded and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in February 2016 this being a minor injury to a member of staff. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

We saw documentation that showed the practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice manager said that there had been no RIDDOR notifications made, although they were aware how to make these on-line. The accident policy had details of how to make a RIDDOR report together with a flow chart for ease of reference.

The practice kept a log of significant events. The records showed the last significant event had been when the computerised records system had failed. This had led the practice to be unable to take digital X-rays or record in patients' dental care records. This event had occurred during 2015. The incident had prompted an internal audit of the computerised records and training days for all staff to consider the learning points from the incident. Discussions with staff showed they understood the issues which should be considered a significant event.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Alerts were received by the practice manager by e mail and were analysed and information shared with staff if and when relevant. The practice manager said the most recent alert had been received in December 2015 and related to issues with a certain type of fire door. This had not affected the practice, but the practice manager had kept the information on file for information.

Reliable safety systems and processes (including safeguarding)

The practice had separate policies for safeguarding vulnerable adults and children. The policies had been reviewed and updated in February 2016. Both policies identified how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. A flow chart and the relevant contact phone numbers were on display in reception and in the safeguarding file.

The practice had an identified lead for safeguarding in the practice and this was one of the dentists. The lead had received enhanced training in child protection to support them in fulfilling that role. We saw the practice had a safeguarding file which contained all of the relevant information and the action plan should the practice have any concerns relating to safeguarding.

Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children. This had been completed on 20 June 2015 in the practice.

There was a policy, procedure and risk assessment to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy directed staff to identify and risk assess each chemical substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally splashed onto the skin. We saw that the cleaning cupboard which was in a public area of the practice did not have a lock. There were cleaning chemicals stored within the cupboard, and a lock would ensure the chemicals were secure.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 22 November 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which directed staff how to handle sharps (particularly needles and sharp dental

Are services safe?

instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy.

We discussed the use of safer sharps with a dentist and dental nurse, who outlined the steps taken to reduce the risks of sharps injuries. There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the bins in the decontamination room and treatment rooms were located off the floor. The guidance indicated sharps bins should not be located on the floor, and should be out of reach of small children. Following the inspection the practice sent evidence that the sharps bins had been attached to the wall in all clinical areas. The Health and safety Executive (HSE) guidance: 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013', was being followed.

Copies of the practice's sharps policy and how to deal with sharps injuries (A sharps injury is a any wound received by pricking, cutting or grazing with a needle or other sharp dental instrument) were displayed in the clinical areas of the practice.

Discussions with dentists and review of patients' dental care records identified the dentists were using rubber dams when completing root canal treatments. Guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. We saw that each dentist had their own rubber dam kit for treating patients.

Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. We saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Two members of staff had completed a first aid at work course, and were the designated first aiders for the dental practice. A poster in the reception area informed patients that there were trained first aiders on the premises.

There was an automated external defibrillator (AED) held in the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Resuscitation Council UK guidelines suggest the minimum equipment required and includes an AED and oxygen which should be immediately available. Staff at the practice had completed basic life support and resuscitation training in July 2015. This training was repeated in October 2015 following the purchase of a new AED.

Additional emergency equipment available at the practice included: airways to support breathing, portable suction, manual resuscitation equipment (a bag valve mask) and portable suction.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies.

Staff recruitment

We looked at the staff recruitment files for six staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff personnel files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that all members of staff had received a DBS check. We discussed the records that should be held in the recruitment files with the practice manager, and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

Are services safe?

The practice had both a health and safety policy and environmental risk assessments. The health and safety policy and the environmental risk assessments had been updated in February 2016. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example: electrical safety, manual handling and emergency medicines

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been updated in May 2015. The fire extinguishers had last been serviced in July 2015. Minutes of staff meetings showed that fire safety was discussed on a six monthly basis, and the last discussions regarding fire evacuation had been in January 2016.

The practice had a health and safety law poster on display in the staff room. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice had an infection control policy a copy of which was readily available to staff working in the practice. The policy had been reviewed and updated within the previous year. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures. Records showed all staff had received training in infection control.

Records showed that regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit in October 2015 scored 100%, so no action plan was necessary on that occasion.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids, which were in date.

There was a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had dirty and clean areas, and there was a clear flow between to reduce the risk of cross contamination and infection. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy.

The practice manually cleaned and rinsed dental instruments after use. We noted the water temperature in the scrubbing sink where the instruments were being cleaned was not monitored. The temperature of the water should be monitored, to ensure effective cleaning. The instruments were then examined using an illuminated magnifying glass to ensure they were clean and free from damage. Finally the instruments were sterilised in one of the practice's autoclaves (a device for sterilising dental and medical instruments). The practice had three steam autoclaves, which were designed to sterilise unwrapped or solid instruments. At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were daily, weekly and monthly records to demonstrate the decontamination processes to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

Are services safe?

We examined a sample of dental instruments that had been cleaned and sterilised using the illuminated magnifying glass. We found the instruments to be clean and undamaged.

There was Information in the practice to identify that staff had received inoculations against Hepatitis B and had received regular blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting this blood borne infection. A sharps injury is a any wound received by pricking, cutting or grazing with a needle or other sharp dental instrument.

The practice had a policy for assessing the risks of Legionella and a Legionella risk assessment. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular water tests, which were recorded.

The practice was flushing the dental unit water lines used in the treatment rooms. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing in the dental unit water lines. This followed the published guidance for reducing risks of Legionella developing in dental water lines.

Equipment and medicines

The practice maintained a file of records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had taken place on electrical equipment at the practice on 5 October 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

There were further records to demonstrate the practice was safe. For example: records to demonstrate the fire alarm, autoclaves and compressor had all been serviced during 2015.

The practice had all of the medicines needed for an emergency situation, as identified in the current guidance.

Medicines were stored securely and there were sufficient stocks available for use. Medicines used at the practice were stored and disposed of in line with published guidance.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Prescription pads at the practice were available and managed effectively. Numbered prescription pads were used and the practice was able to track their movement. The prescription pads were stored securely when not in use.

Radiography (X-rays)

The dental practice had seven intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the whole mouth including the teeth and jaws. X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The local rules identified the practice had a radiation protection supervisor (RPS) this was one of the dentists and a partner in the practice. There was also a radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Emergency cut-off switches for the X-ray machines were located away from the machines and were easily accessible for staff.

Records showed the X-ray equipment had last been serviced in April 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

The practice used digital X-ray images; these rely on lower doses of radiation, and do not require the chemicals to develop the images required with conventional X-rays. This makes them safer for both patients and staff.

Are services safe?

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant & nursing mothers.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. Discussions with dentists identified that grading of the radiographs occurred every time an X-ray was taken, to judge if the equipment was working correctly. We saw examples of this in practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held dental care records for each patient. We saw a small number of patient care records to confirm what the dental staff had told us during the inspection. These records included all information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and included examination of the soft tissues including the tongue and the jaw and neck.

Patients at the practice completed a medical history form, or updated their details. The practice scanned the medical history forms onto the patient's computerised dental records and the form was checked by the dentist before treatment began. In each treatment room a large screen allowed patients to view their medical history form. There was also a digital signature pad to let patients sign directly into the computerised records to confirm any changes or if the details remained the same. The patients' medical histories form included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that comprehensive assessment of the periodontal tissues (the gums) and soft tissues of the mouth had been undertaken. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw dentists used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had a large waiting room, and information for patients covered the walls and shelves. There was assorted literature about the services offered at the practice, as well as health promotion advice. This included posters giving general health advice, and information about other local services in the community. There were posters and leaflets providing information about improving patients' oral health; much of this was aimed at children. For example: Avoiding tooth decay and acid erosion. For adults there was information about the risks associated with smoking, and information about helplines and support with stopping smoking. There were also leaflets and posters about using the 111 service.

A dentist explained that many of the children seen at the practice were at risk of dental decay due to poor diet or too much sugar in their diet. As a result the practice routinely provided fluoride application varnish and fluoride toothpaste to all children identified as being at risk.

Staff at the practice said they always got involved with national campaigns, such as: national smile month and national no smoking day in March.

We saw examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet with regard to oral health. With regard to smoking dentists had particularly highlighted the risk of dental disease and oral cancer.

Staffing

The practice had six dentists; there were six trainee dental nurses one of whom also worked on reception, plus two receptionists and one practice manager. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We saw the staff training records and these identified that staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: radiography (X-rays), medical emergencies, hands on endodontic practice and safeguarding. We saw that there were many clinical courses and updates available to staff, and training certificates in files evidenced what training had been completed.

Are services effective?

(for example, treatment is effective)

The practice manager was also a registered dental nurse and was overseeing the training, development and support of the six trainee dental nurses.

Records at the practice showed that appraisals had been completed during 2015 for all staff. These had been completed during the period January to March. We saw evidence in five staff files that appraisals had taken place. We also saw evidence of new members of staff having an induction programme. We spoke with two members of staff who said they had received an annual appraisal at head office.

Working with other services

The practice made referrals to other dental professionals when it was clinically indicated that a referral should be made. For example: when complex treatment was required, for difficult extractions, sedation services or for orthodontic treatment. The practice usually referred to the community dental service or one of the maxillofacial units at the local NHS hospitals.

Records within the practice identified that referral for patients with suspected oral cancer had been made within the two week window for urgent referrals, and these were tracked to ensure they had been received and the patient seen. The practice manager said that the patient was also given a copy of the referral, so they knew who the referral had been made to.

Patients' care records showed that referrals had been made, and that patients' had been involved in discussions about the referral and the reasons why it was necessary.

Consent to care and treatment

The practice had a consent policy which made reference to capacity and the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

The practice recorded consent directly into the patients' electronic care notes. This was done by use of an electronic signature pad, and happened while the patient was sat in the dental chair. The dentist was also able to discuss the treatment plan, and the patient was able to see this on a large screen in the treatment room. When patients' went back to reception they were given a printed copy of their treatment plan and the costs.

Discussions with the dentists showed they were aware of and understood the use of Gillick to record competency for young persons. Gillick competence refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Throughout the inspection we observed how staff were interacting with patients. We saw that staff were friendly and polite. We saw examples of reception staff making efforts to put patients at ease. Our observations showed that patients were treated with dignity and respect throughout the dental practice.

The reception desk was located inside the front door near the waiting room. We discussed the need for confidentiality with reception staff who explained how this was achieved. Staff said if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen, such as an unused treatment room. Staff said that all details of patients' individual treatment was discussed in the privacy of the treatment room.

We observed several patients being spoken with by staff throughout the day, and found that confidentiality was being maintained both at the reception desk and in the treatment room. We saw that patient dental care records were held securely and computers were password protected.

Involvement in decisions about care and treatment

We received feedback from 33 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. Feedback was positive with patients identifying positive experiences at the dental practice. The CQC comment cards identified that dentists took the time to explain the treatment and involve patients in any decisions. Seven patients made specific reference to dental staff being friendly, open and approachable. Five patients said they were able to ask questions or raise any worries or concerns.

The practice offered mostly NHS dental treatments and costs for both NHS and private treatments were clearly displayed in the practice. The cost of NHS treatment within the banding scheme was also identified in the detailed practice leaflet.

We spoke with three dentists, and three dental nurses who explained how each patient had their diagnosis and dental treatment discussed with them. The treatment options and costs involved were explained before treatment started. Patients were given a written copy of the treatment plan which included the costs.

Where necessary dentists gave patients information about preventing dental decay. This included discussions about smoking and diet, and the effects of carbonated drinks with a high sugar content on the patient's teeth, gums and mouth. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines. Information posters for patients regarding the frequency of dental visits and the NICE guidelines were displayed within the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was situated in a building close to the town centre. There was car parking available at the rear of the practice and level access to ground floor treatment rooms.

The practice had separate staff and patient areas, to assist with confidentiality and security. The ground floor treatment rooms were accessible to patients in wheelchairs or with restricted mobility.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

We spoke with two patients during the inspection. Patients said that getting an appointment had been easy. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours, and usually the same day.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist.

Tackling inequity and promoting equality

The patient areas of the practice were situated over two floors of a building close to the centre of Hucknall. There were three treatment rooms on the ground floor which provided level access from the street to the treatment room. This included level access to the back door of the practice. This allowed patients who may have difficulty accessing services due to mobility or physical issues to be seen. Access to the front door of the practice was by means of a short set of steps.

The practice had good access to all forms of public transport with a bus stop located close by, and Hucknall tram stop a short walk away. There was disabled parking to the rear of the practice, although the entrance designated for patients in wheelchairs or with restricted mobility was along a narrow corridor outside. Staff said patients had been able to access the practice this way, although it appeared to be a tight space particularly for patients in wheelchairs.

There was a portable hearing induction loop situated in reception. The Equality Act (2010) requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices.

Patients said that they were usually seen on time, and making an appointment was easy, as the reception staff were efficient, approachable and helpful.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Staff said that there were very few patients who could not speak English, and if language was a problem the patient usually brought someone to interpret therefore avoiding the need for interpreters.

Access to the service

The practice was open: Monday to Friday: 8 am to 6 pm. The practice was closed at the weekend.

Access for urgent treatment outside of opening hours was by ringing the practice and following the instructions on the answerphone message. Alternatively patients could ring the 111 telephone number for access to the NHS emergency dental service.

Patients were sent a text reminder that their appointment was due, and in some cases a letter. Staff also made telephone calls to patients the day before their appointment to remind them that their appointment was the following day.

Concerns & complaints

The practice had a complaints procedure which had been reviewed in February 2016. The complaints procedure was for patients who wanted to make a complaint. The procedure explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included NHS England and the Parliamentary and Health Service Ombudsman.

Information about how to make a complaint was displayed in the practice waiting rooms, and in the practice leaflet.

From information received before the inspection we saw that there had been no formal complaints received in the past 12 months.

Are services well-led?

Our findings

Governance arrangements

There was a clear management structure at the practice, with staff having set roles and responsibilities. The practice had a registered manager, who was also the practice manager. Discussions identified the registered manager understood their role within the registered service.

The practice was part of a larger corporate provider. Information about the organisation, including contact details for head office, and other dental practices within the organisation was available in the practice leaflet. Staff said they understood their role and could speak with managers within the organisation if they had any concerns. Staff said they understood the management structure at the practice and the organisation. We spoke with four members of staff who said they were happy working at the practice, and there was good communication within the staff team. We observed a number of positive working relationships throughout the day.

We reviewed a number of policies and procedures at the practice and saw that they had been reviewed and where relevant updated during February 2016. The organisation had a management plan which included the review and updating of policies and procedures.

We were shown a selection of patient dental care records to assess if they were complete, legible, accurate, and secure. The dental care records were computerised records and the examples we saw contained sufficient detail.

Leadership, openness and transparency

The practice had a management structure for meetings throughout the year. Full staff meetings were scheduled for every month, and minutes were available to all staff. We saw minutes identified topics such as health and safety and staff training. Dentists had annual meetings organised through head office, and dentists also met quarterly for peer review.

We spoke with several staff at the practice and staff said there was an open culture. Managers were available to discuss any concerns and there was support available regarding clinical issues. Staff said they were confident they could raise issues or concerns at any time. Observations showed there was a friendly attitude towards patients from all of the staff. Discussions with different members of the team showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

A poster showing the General Dental Council's (GDC) nine principals to meeting the GDC standards was on display in the practice. Discussion with staff at the practice showed they were aware of the principals and were able to identify them and discuss what that meant for the dental practice.

The practice had a whistleblowing policy which was had been reviewed in February 2015. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with a dental nurse who was able to give a clear and thorough account of what the procedures were for, and when and how to use them. The practice had made two types of whistleblowing procedure available to staff. One for raising concerns internally and one for doing so with external agencies.

Learning and improvement

The practice had introduced measures to improve the quality of the service offered to patients. In the twelve months up to the inspection a digital signature had been introduced which allowed patients to sign directly into their electronic dental care records. As a result patients were able to show their consent, and the need to keep detailed paper records had been removed.

The practice manager demonstrated the schedule of audits completed throughout the year. This was for both clinical and non-clinical areas of the practice. The audits showed both areas for improvement, and identified where quality had been achieved, particularly in respect of clinical areas. During the inspection we saw completed audits for infection control, patients' dental records and radiographs (X-rays). Records showed that audits of other areas of the practice were carried also completed on a regular basis, and the results analysed to drive improvements.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing

their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period.

Practice seeks and acts on feedback from its patients, the public and staff

In the waiting room the practice had a feedback station. This was where the practice's suggestion box and the NHS Friends & Family (F&F) comment box were located. Close to the feedback station the practice had displayed posters giving feedback to patients about the results of the F&F comments and the results of the practice's own patient satisfaction survey.

The NHS Family and Friends comment box was specifically to gather regular feedback from the NHS patients, and to satisfy the requirements of NHS England. The responses within the boxes were analysed on a monthly basis.

We visited the NHS Choices website and reviewed the information and comments that patients had left about the practice. The website identified that 288 patients had provided feedback and 96% said they would recommend this dentist.

In the 12 months leading up to the inspection there had been seven comments posted on the NHS Choices website. Most of the comments were positive. The practice had provided a response to all of the comments, and had given contact details and asked the posters of negative comments to contact the practice to address the issues.

The practice also conducted its own survey on a six monthly basis with patients being targeted for each dentist. The results were analysed, discussed in staff meetings and were used to make improvements within the practice. A recent survey had identified patients wanted more information leaflets about different treatments. As a result new leaflets had been made available covering a range of different treatment options.